Commentary

Getting the Work Done

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Graduations are times to celebrate, to launch, to affirm, to reflect. We are pleased to join the festivities and solemnities by publishing a gift to graduates, their families, their faculties, and their patients, the Graduation Speech presented in 1997 by Faith Fitzgerald, MD at the University of California, Davis School of Medicine.

It is no wonder that the graduates chose Dr Fitzgerald to speak. Her intellect is dazzling; her choice of language and stories is memorable. Her brain, spirit, and tongue are effectively linked to each other and to her vast clinical experience. She is a master learner and teacher. Dr Fitzgerald's commitment to patients is her basic fuel and her ability to teach is her vehicle. Her catholic abilities are not limited to medicine, however. Her devotion to her mother and friends is a fine example for others; her interests in literature and history add sparkle to conversations and depth to relationships.

Trained in internal medicine at University of California, San Francisco, Dr Fitzgerald has held faculty appointments there and at the University of Michigan, and, since 1980, at University of California, Davis where she is now Professor and House Staff Director in the Department of Medicine. She has served on over 25 hospital and medical school committees since 1980, and was Chief of Staff in 1995. She has received university and national awards as a student, teacher and mentor and has been visiting professor to almost 70 institutions from Pennsylvania to Pakistan. She is author of some 125 papers, chapters, books, and letters to the editor, and is the subject of numerous video and audio tapes. Topics include heroes in medicine, sarcoidosis, care of mammal bites, science versus scam, and medical education in Russia. Dr Fitzgerald's astute work as reviewer for numerous journals has helped raise standards and accessibility of the literature of medicine. She is currently Governor of the Northern California Chapter of the American College of Physicians.

As you read Dr Fitzgerald's stories and exhortations, think about your own experiences and values, about your own fuel, about the meaning in your own life. Consider writing about them. We hope this paper will do for you what it did for those who heard the presentation: uplift, focus, renew.

LINDA HAWES CLEVER, MD
Editor

Over time we, as doctors, have played many parts in the drama of medicine. Doctors are the people who care for the sick. Sometimes we have been scoundrels and sometimes saints; sometimes we have been worshipped and sometimes scorned. We are servants, parents, and partners of our patients. Now we have yet another role assigned to us by society: we are but one in a large group of "health care providers," functionaries in systems of managed care. Patient roles have also varied throughout history, but less so than those of doctors. The word "patient" is from Latin, meaning "one who suffers." Patients were and still are the sick, the injured, the despairing. Because doctors have a special duty to suffering people, patients can make demands of us that we must, by oath, fulfill.

Now we enter a new time: some who seek our services are "clients" or "consumers," and need not be ill to put claim to our "provider" obligation. Unlike patients, clients are often healthful; from their provider they anticipate improvement at most and maintenance at least of that healthy state. But I believe we should distinguish between the well consumer and the sick patient—the relationships that we form with each are quite different. Well people *can* be consumers: they have the strength,

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wit, and time to negotiate. Well people do not really need doctors: nurses, physician's assistants, nutritionists, and many other experts can render advice and preventive services. Frankly, well adults are probably better off not seeing doctors. We tend to try to find things wrong with them, lest we miss something. Perhaps we should have two systems of medical care: one for the well, served by providers, and one for the sick, served by doctors.

Sick people cannot be consumers in the mercantile sense, and it is a cruel deception to suggest that they can. They can't shop around. They do not want bargains even if the merchandise is only slightly defective. They can't return faulty therapy for a refund. The sick are vulnerable, and they need champions. The managers, insurance agents, and economists who have turned the sanctum of the consulting room into an open market place cannot be champions of the sick: they have different goals. For these professionals, paradoxically, care of the sick is not the purpose of medicine, but evidence of its failure. Many actually believe that preventive medicine will stop sickness. They are wrong. Medicine may postpone illness or detect disease earlier, but sickness will still occur. Sick people will need doctors to look after them, because no one else can do it as well.

The covenant between doctors and patients is far more serious than that between providers and consumers. It requires more trust on the part of the patient, and more skill and commitment on the part of the doctor, than called for by commerce. While many other human negotiations deal with possible life and death decisions—including such mundane activities as buying a car or a choosing a flight on a commercial airline—none does so with such stunning immediacy as that that takes place between doctor and patient. The intimacy that develops between doctors and patients is hard to imagine in any other field—the intimacy grows through, for example, exploration of socially taboo subjects and forbidden parts of the body; invasion of family secrets and shames; and potentially permanent alterations of the patients' minds and bodies through drugs or surgery. It is quite extraordinary.

What are the core values of the practice of medicine, exposition of which is especially important in these troubled times? What can doctors cling to as essential even as we are buffeted by the rapidly shifting winds of fads and politics?

In most managed systems, efficiency is key; in some, an assembly line system—in which the patient is a "work unit," one seen even every 10 to 15 minutes no matter what his or her need—is promoted. This is an abomination. It dehumanizes both patient and doctor, and we must refuse to go along with it.

But it is not just managed care that is the villain. A medical student once told me the following story: when he was on rounds with an intern during his third-year surgical clerkship at another university hospital, the student went into each room to listen to and examine the patients. The intern, meanwhile, telephoned for laboratory data, reviewed the chart, checked the fluid balance, and surveyed the monitors. Finally the intern, frantically recording data on little cards and in the charts, turned angrily on the student. She said, "Look, we have a lot to do. The attending is meeting us in 15 minutes and has to get his billing notes written. I want to go home before the turn of the century. If you insist on seeing every patient, we will never get the work done."

What is "the work"? Have documentation, the recording of laboratory and technologic information, and the convenience of doctors become "the work"? When did contact with patients begin threatening to interfere with the work of medicine? Certainly this transformation happened before the onset of managed care. For decades, house staff and medical students as well as some senior doctors have been involved with the evolution of a culture and language suggesting that some see patients as an impediment to education, research, and even to the best clinical care. You've witnessed it. In teaching, more predictable simulated patients may be preferable to real ones; CD-ROM or syllabus collections of case histories and physicals are promoted as teaching tools, while patients in hospitals, clinics, and nursing homes complain that they get little time with doctors; and admissions of sick patients are called "hits"—the house officer with the most "hits" has a "black cloud." Diverting admissions to other services is considered clever by some, and a no-show in the clinic may evoke relief rather than disappointment. In the past, these attitudes underwent dramatic reversal when the house officer entered practice, but capitated managed care may now perpetuate the pernicious concept of the patient as the enemy of "the work." Why did this happen?

Most of it, I believe, has to do with both the desire of doctors to do the best job of doctoring they can and the fear of not being able to do it if there is too much work. As with the intern in my story, doctors are distracted from their work—being with patients—by increasing amounts of secretarial, technical, clerical, messengerial, and now even accounting work. You fear that if you don't do these things, no one else will—and you may be right. But if doing them means you can't do the work of a doctor, and no one else can, something is very wrong.

How can we refocus this diverted attention? There is one way: we must encourage doctors at all levels to indulge in the genuine joy of being with patients and refuse to yield to the forces that stand between us and them. If these forces are built into the system, the system must be resisted and reconstructed with the patient at its center.

Efficiency is good, but seeing efficiency as a greater virtue than empathy stands between us and our patients. We must make time to listen and to think.

Research and technology are the parents of medical miracles, but they may stand between doctors and patients if experiments, lab tests, or images are more real to doctors than their patients. Technology is supplemental to knowledge of the patient; it cannot substitute for it, because over-reliance on technology leads

doctors to do things to things instead of for people. Patients must be the motive for, and never simply the material of, clinical academic inquiry.

Documentation is essential but can stand between us and our patients if it becomes more urgent than what is actually documented. We cannot, as some doctors now do, spend more time with the chart than with the patient. Charts do not suffer.

Even the highly valued thirst for information can stand between us and our patients. You may know all of the science of medicine (unlikely), but unless you apply it wisely to your patient at that time, you are not acting as a doctor. When the medical literature becomes more true than the patient; when reading, computing, or hearing about "virtual patients" becomes more compelling than interacting with actual patients; or when you would rather discuss the treatment of asthma in the abstract than treat asthma in the clinic, it is time to consider well what you are doing. As William Osler said, "To study the phenomena of disease without books is to sail an uncharted sea, while to study books without patients is not to go to sea at all."

The caring doctor's very presence with the patient is a most potent therapeutic force. Doctors are analgesics, anodynes, and anxiolytics—for not only their patients, but also the families of their patients. And, doctors, you do all of this with few to no side effects. With computerized questionnaires and laboratory tests, you can often quickly discover pathology. It is only through listening—even to the silences of the inarticulate—that you can discern and treat the patient's disease, the cause of their suffering.

To be a good doctor, you must have empathy, the ability to participate in another's feelings or ideas. You cannot have empathy for strangers, because you don't know their feelings or ideas. You may have pity, but that is a shallow and unsatisfying substitute. You must therefore *know* your patient—not just his or her present crisis, but the unique human being in whose life it is occurring. Doctors must know a patient's character and culture as well as spiritual and physical responses. Where does their disease fit in the pattern of their lives? How will they cope, and with what tools of intellect, emotion, and support? What future do they see, and from what antecedents does this vision derive? The more you know of the man or woman or child for whom you care, the more expertly you may apply your skills. All that you know of human science is part of the practice of medicine, but so is knowledge of the human arts and history, literature, philosophy, and language. Most importantly, the core of medical practice (throughout the ages to now) is knowing the patient. You can only know your patient by listening, touching, and recognizing him or her as a richly complex person of great value and infinite interest.

How do we restore the patient to the center of medicine? You must do it. You must insist on rounds at the bedside rather than in the hall or conference room, on enough time in both the hospital and the clinics to get to know the patient, and on the importance of patient contact over all other methods of medical care and education. You must do this as efficiently and inexpensively as possible, with pertinent notes, concurrent judicious use of laboratory and diagnostic technology, and the continual acquisition and generation of knowledge and skill by reading, lecture, precept, and experiment. But you must resist the temptation to do all of these things at the expense of direct patient interaction, which is the last thing you should ever surrender. If anyone or any system begins to imply the idea that patients are anything but an honor, or if you find yourself behaving or speaking as if patients are a distraction, resist with all your might.

American patients repetitively say that what disturbs them about modern medicine is that doctors don't spend enough time with them. We don't listen. Charlatans spend time with their patients. But imagine what we might accomplish if we could combine the interpersonal skills of "quacks" with the science of orthodox physicians.

What will you get if you accomplish this task? Well, for one, you will create a great collection of memories to enrich your life. I remember once asking an old man, who was dying of heart disease and knew it, how he was. He burst into tears. I felt terrible.

"What is it?" I asked.

"The world is ending," he said.

I was young and foolishly tried to reassure him. "No it isn't," I said.

"Mine is," he answered. He was right: each person's death is a private apocalypse. And he was in mourning for those he loved. His family was losing one person; he was losing all of them.

I remember the English professor the nurses called me to see postoperatively because they thought she had had a stroke. She was speaking gibberish, they said. Actually, she was reciting Chaucer in Middle English to distract herself from the pain. I remember the pimp for whom I had felt sympathy as I sewed up his knife cuts in the emergency room. When he quit the pandering trade because it was too dangerous, he opened a quite successful pornographic ice cream parlor and sent me and other house staff free samples of his wares. I also remember the elderly Irish woman, who had been admitted for placement. Medically, she was not that interesting, until her social history revealed that the ship carrying her to New York as a girl had sunk after hitting an iceberg—the *Titanic*.

What I learned from lectures and books when I was a resident almost 30 years ago has undergone revolutionary revision. Much of what I memorized so assiduously, it turns out, was wrong. Technology and procedures have evolved rapidly, and most of what doctors now use was unknown to me then; what I once used is now archaic. The pharmacopoeia from the 1960s and 1970s is dusty history for the most part. What remains enduring and valuable from my medical school and house officer days, and ever since, is what I have learned from patients. They teach perception, sensitivity, and common sense: they will direct you in the application and transformation of scientific information to clinical wisdom.

What are the risks you take if you follow this course? If you spend time with your patients, you might get criticized, as was the student in my story. As a practicing physician in some managed care systems, you might even get fired. For millennia doctors have faced infection and death to serve their patients: can you risk criticism or loss of income for that same high purpose?

If you will keep the patient in the center of medicine, even in the midst of the chaos of systemic change, you will have the most wonderful adventures anyone could: you will experience history through your patients, journey with them in their joy and despair, and hear stories no author could imagine. You will see the human spirit in its most vivid moments of triumph and courage. And you will know that your patients were better because your art, your science, and—most importantly—you were there with them through it all. This is a doctor's work. Don't let anyone divert you from it.